County of Los Angeles
CHIEF EXECUTIVE OFFICE
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WILLIAM T FUJIOKA
Chief Executive Officer

July 29, 2011

To: Mayor Michael D. Antonovich
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

From: William T Fujioka
Chief Executive Officer

REPORT ON THE STRUCTURE FOR A SPECIAL COMMITTEE AND BUSINESS PLAN ON HEALTH CARE REFORM GUIDELINES

On September 21, 2010, on a motion by Supervisor Molina, your Board instructed the Chief Executive Officer (CEO), in consultation with the interim Director of Health Services to establish a team of experts, including health business professionals, to evaluate our existing system and provide your Board with "business plan" type recommendations for which services, specialty and otherwise, are most likely to be self-sustaining, competitive, and profitable under health care reform, and provide recommendations for how to best strengthen and utilize those services to support the vitality of the County's health care system as a whole, and report back within six months on the progress being made with reports thereafter.

On November 30, 2010 we reported to your Board on the initial framework, including: the composition for the special committee; formation of an Executive Leadership Team; the Task Force's scope; and efforts that were underway by a Waiver Planning Group. We further indicated that the next report would provide information on the proposed Task Force structure and model, and that it would include input by the incoming Director of Health Services, Dr. Mitchell Katz.

Following his start of service with the County on January 3, 2011, Dr. Katz reviewed the instruction from your Board and, in discussion with Supervisor Molina, requested that he, as Director of Health Services, serve as the lead expert on this critical effort. Therefore, he is developing the business plan which will address how the Department of Health Services (DHS) will be self-sustaining and competitive by 2014. Dr. Katz anticipates providing your Board with the business plan by August 15, 2011.

The business plan will address four major areas: 1) maximizing enrollment in the DHS Healthy Way L.A. program; 2) retaining covered members in the DHS delivery system, by improving customer service and patient satisfaction; 3) increasing revenue captured for our currently insured patients (e.g., reducing denied days), safeguarding our ability to serve individuals who will remain without health coverage; and 4) improving the health delivery cost basis by continuing to seek more efficiencies in the system.

As your Board is aware, since assuming his position as the Director of DHS, Dr. Katz has also developed and is implementing DHS' Strategic Plan, which contains critical components necessary for DHS to comply with the requirements of the 1115 Waiver, "California's Bridge to Reform" (Attachment I), as well as to enable the DHS to address the challenges of health reform implementation. Both the DHS Strategic Plan and the 1115 Waiver implementation, mentioned below, include components which are critical to the DHS business plan.

The DHS Strategic Plan includes five major goals: 1) Transform DHS to an integrated high-quality delivery system, including community-based primary care and behavioral health providers; 2) assure sufficient capacity of hospital-based services to meet the needs of the County's residents; 3) create a modern information technology system that improves the care of DHS patients and assures efficient use of resources; 4) assure the long term financial well-being of the County's safety net health services; and 5) foster a culture of empowered staff and community, organized labor, and university partners constantly looking for opportunities to improve the service provided to patients.

The DHS Strategic Plan reflects strategies and objectives to achieve these goals and outcomes by which success can be measured. DHS will provide an update on strategic plan components which have been completed and a timeline for completing the rest of the components when it reports on the DHS business plan, no later than August 15, 2011.

Further, as reported on a monthly basis by DHS, the Department is actively engaged in implementing the 1115 Waiver components, as most recently reported in its July 13, 2011 report (Attachment II). Of particular significance in the report is the progress on the Low Income Health Program (LIHP), in partnership with the Department of Mental Health (DMH), and the milestones related to the Delivery System Reform Incentive Payment Pool (DSRIP), both of which are critical to ensuring that DHS and DMH can maximize the amount of 1115 Waiver revenues available to the County for the transition to health reform.

Finally, it should be noted that our Office has established a legislative task team that will work with DHS and other County departments potentially affected by health reform, including DMH and the Departments of Public Health and Public Social Services, to identify and proactively address areas requiring regulatory and/or legislative action to ensure pursuit of the County's best interests in health reform implementation. The legislative task team expects that the critical legislative development will occur during calendar year 2012 leading to the January 2014 effective date for health reform implementation, and the work plan they are developing will inform the County's legislative program for the coming year. The involvement of your Board offices will also be important to the success of this effort, and we will continue to keep your Board Deputies engaged in this effort.

While we will work with DHS to provide your Board with reports on these continuing efforts, this memorandum will close out the September 21, 2010, instruction to our office for a report with "business plan" recommendations.

If you have any questions, please have your staff contact Sheila A. Shima, Deputy Chief Executive Officer, at (213) 974-1160 or at sshima@ceo.lacounty.gov.

WTF:SAS
MLM:gl

Attachments

c: Executive Office, Board of Supervisors
County Counsel
Health Services
Mental Health
Public Health
Public Social Services

072911_HMHS_MBS_Health Care Reform Special Committee

Attachment I

Health Services
LOS ANGELES COUNTY

April 4, 2011

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **DEPARTMENT OF HEALTH SERVICES (DHS) STRATEGIC PLAN**

I am pleased to transmit the new DHS Strategic Plan. This plan is a roadmap for the vital system restructuring which DHS must achieve to fulfill its health care mission. Specifically, it incorporates the goals of the new 1115 Waiver and prepares DHS for health care reform.

The draft strategic plan was widely distributed, including within DHS, other County departments, community and university partners and your offices. Comments and feedback were received from all sectors. I appreciate the time and effort which so many put into reading and responding. The comments and ideas are incorporated into the plan. Although we have taken the "draft" off the plan and are sharing this widely as the plan, it will continue to evolve as we strive to implement it.

If you have any questions or need additional information, please contact me.

MHK:jp

Attachment

c: All DHS Employees
Community and University Partners
Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

www.dhs.lacounty.gov

Los Angeles County
Department of Health Services
Strategic Plan
March 2011

Mission

To ensure access to high quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at Department of Health Services (DHS) facilities and through collaboration with community and university partners.

Vision

To be the most effective and innovative county health care system in the country.

Values

- We put our patients first.
- We provide care that is culturally-competent, linguistically appropriate, and geographically accessible.
- We learn continuously and strive to work at the top of our skill set.
- We empower our patients, their families, and their communities to be involved in their health care.
- We collaborate with other county departments, health providers, educational institutions, and advocacy groups.
- We function as an integrated, coordinated system across facilities, service types, and geography.
- We embody the values of the Los Angeles County government including accountability, can-do attitude, integrity, leadership, respect for diversity, and responsibility.

Strategic Plan Goals

1) Transform the Los Angeles County Department of Health Services from an episodic, hospital focused system to an integrated high-quality delivery system including community-based primary care and behavioral health providers focused on prevention, early intervention, and primary care with appropriate referrals for specialized services.

2) Assure sufficient capacity of hospital-based services to meet the needs of the residents of Los Angeles County.

3) Create a modern IT system that improves the care of our patients and assures efficient use of resources.

4) Assure the long term financial well being of the safety net health services in Los Angeles County.

5) Foster a culture of empowered staff and community, organized labor, and university partners constantly looking for opportunities to improve the services we provide to patients.

Strategic Goals with Strategies and Objectives

Strategic Goal 1:

Transform the Los Angeles County Department of Health Services from an episodic, hospital focused system to an integrated delivery system including community-based primary care and behavioral health providers focused on prevention, early intervention, and primary care with appropriate referrals for specialized services.

Strategy 1: Develop a centrally-managed, web-based, accessible system for determining eligibility and implementing enrollment of patients for Medi-Cal, Healthy Families, and other Federal, State and County funded programs.

Objective 1: Determine best existing eligibility system for Los Angeles County.

Objective 2: Determine sites where clients will be able to enroll.

Objective 3: Train application assistors to enroll patients.

Outcome for success: Ninety-five percent of continuity patients are screened through the system.

Strategy 2: Create a method of assigning managed care (e.g., Healthy Way LA, Seniors and Persons with Disabilities) and other patients with chronic diseases to medical homes at the appropriate level and facility including Public Private Partner (PPP) providers and allow for ongoing panel management and emphasis on continuity of care at the primary provider level.

Objective 1: Develop assignment method in consultation with PPP providers.

Objective 2: Implement across primary care sites including PPP providers.

Outcome for success: Ninety-five percent of managed care and other patients with chronic diseases are assigned to a medical home.

Strategy 3: Develop a web-based system of record that identifies the medical home of safety-net patients, including those of private providers that can be used at hospital and community-based sites.

Objective 1: Choose system of record.

Objective 2: Implement across primary care sites including PPP providers.

Outcome for success: All safety net providers can determine primary care home for patients needing follow-up care.

Strategy 4: Increase the number and capability of available primary care Medical Homes for patients with chronic illness or in high need for coordinated care (e.g., young children, substance users) both within the Department of Health Services (DHS) and among its PPP affiliates.

Objective 1: Identify staffing model and roles within DHS facilities needed to implement medical home teams.

Objective 2: Develop an ambulatory care site staffing model to optimize the quality and efficiency of care.

Objective 3: Expand the roles for providers, for example, having registered nurses provide chronic disease management for patients with diabetes and congestive heart failure, having pharmacists actively involved in drug choices and adherence counseling, having health educators function as health promoters or "promotoras."

Objective 4: Develop job description and requisition for medical evaluation assistant and hire into position.

Objective 5: Train DHS primary care providers to function as Medical Home teams.

Objective 6: Work with patients and their advocates to determine characteristics important to make clinics "patient-centered," and culturally/linguistically appropriate.

Objective 7: Implement web-based registries that support the functions of the Medical Home and allow measurement of quality metrics at both facility and system levels.

Objective 8: Expand care management (e.g., screening tools, use of treatment protocols) in primary care homes.

Objective 9: Identify and enroll appropriate patients into disease management.

Objective 10: Create extended hours of primary care to include evenings and weekends.

Outcome for success: Ninety-five percent of patients with chronic illness or need for coordinated care have a medical home.

Strategy 5: Improve care coordination

Objective 1: Establish system-wide policies and procedures that support the coordination of transitions in patient care (e.g., primary home to specialty care, primary home to hospital, hospital to primary home, etc).

Objective 2: Develop and implement mechanism for exchange of patient health information between hospitals and medical homes.

Strategy 6: Improve outpatient efficiency

Objective 1: Perform clinic redesign to reduce clinic cycle time.

Outcome for success: Decrease cycle time within redesigned clinics by 10%.

Strategy 7: Improve patient experience with ambulatory care.

Objective 1: Improve patient satisfaction.

Outcome for success: Meet or exceed the satisfaction scores for peer organizations.

Strategy 8: Improve quality of ambulatory care

Objective 1: Develop comprehensive continuous quality improvement culture within ambulatory care: choose evidence-based quality goals (e.g. HEDIS measures), measure them prior to intervention, develop strategies for achieving goals, measure them in local settings and across the system.

Outcome for success: Meet or exceed goals for receipt of recommended care (e.g., rate of mammogram screening, asthma care, screening for colon cancer). Exceed national average, for at least 75%, of relevant CMS processes of care measures.

Strategy 9: Increase the provision of urgent care services for patients who need to be seen right away but do not require emergency care.

Objective 1: Expand urgent care service hours, especially during early evenings and on weekends.

Objective 2: Expand nurse advice line or other methods to redirect patients needing episodic or urgent care to the appropriate facilities BEFORE they come to the emergency department (ED).

Objective 3: Educate patients on access options and appropriate use of the ED.

Strategy 10: Increase the availability of specialty care services to DHS and other safety net patients.

Objective 1: Implement standardized referral guidelines for specialty care clinics.

Outcome for success: Ten percent reduction in inappropriate referrals.

Objective 2: Establish standardized guidelines for when clients should be discharged from specialty care.

Outcome for success: Ten percent reduction in repeat visits to specialty care.

Objective 3: Develop an e-referral system to ensure that persons needing specialty care are seen promptly, that the referral is appropriate and that needed diagnostics are performed prior to the visit, that the referring primary care provider is linked directly with the specialist for consultation, that the report is returned easily and quickly and those requiring specialty advice only receive it without the patient being required to make a visit.

Objective 4: Determine what volumes of specific specialty services are needed at what facilities to meet the anticipated needs of the patients receiving primary care within DHS and its partners, and plan for their availability.

Objective 5: Work with medical school partners to provide an optimal match between specialty care services and the needs of the safety net population.

Objective 6: Target specialty clinics that are in greatest demand for evaluation of the appropriateness of existing patients and the potential for redirection of those patients into Medical Homes, operated either by DHS or its PPP providers.

Objective 7: Develop innovative methods for enhancing the capacities of specialty services (i.e., retinal cameras, telemedicine, linkages among designated PPPs or DHS primary care facilities and specialty clinics, use of physician extenders, partnerships with private specialists).

Objective 8: Establish "enhanced" or "specialized" medical homes within the system that pair primary care and specialty services in an integrated approach.

Objective 9: Establish specialty/diagnostic centers in all DHS regions to provide greater access to and integration with community Medical Home partners.

Objective 10: Measure and address the no-show rate at subspecialty clinics.

Strategy 11: Integrate physical health services with behavioral health services.

Objective 1: Intensify joint planning and collaboration with the Departments of Mental Health and Public Health.

Objective 2: Determine priorities for integrated services.

Strategy 12: Develop ability to offer home care services to appropriate patients.

Strategy 13: Increase the number and capability of integrated school health centers.

Strategy 14: Improve the exchange of patient information between DHS and both private providers and other County Departments.

Objective 1: Actively participate in the Los Angeles Network for Enhanced Services (LANES) to ensure membership and inclusion in a county-wide healthcare information exchange plan.

Objective 2: Establish the information systems foundation for future electronic exchange and begin routine electronic information exchange of selected health and human services data among County departments serving the same individuals.

Strategy 15: Develop a DHS-wide approach for high risk-high cost individuals with multiple problems to more effectively address issues of substance abuse, mental illness and homelessness.

Strategic Goal 2:

Assure sufficient capacity of hospital-based services to meet the needs of the people of Los Angeles County.

Strategy 1: Provide assistance to assure the successful opening of Martin Luther King, Jr. (MLK) hospital on schedule in 2013, including the development of rational and effective linkages between MLK and those DHS services provided on the campus or in the region (i.e., MLK Multiservice Ambulatory Care Center, primary care, emergency transfers, and psychiatric services).

Strategy 2: Decrease the average length of stay for hospitalized patients.

Objective 1: Implement inpatient clinical pathways in those areas where there is consensus.

Objective 2: Develop non-hospital alternatives for hospitalized patients who are no longer acutely ill but cannot be discharged to their home.

Objective 3: Optimize hospital operations/throughput (e.g., ED to inpatient transition, admission, discharge, bed turnover, diagnostic or procedural capacity constraints.)

Strategy 3: Decrease unnecessary ED visits through increased provision of primary care and urgent care.

Strategy 4: Assess the needed bed capacity within DHS.

Objective 1: Maintain accurate timely data on hospital capacity and utilization at all DHS facilities.

Objective 2: Deploy available strategies for immediately decreasing capacity in sites where DHS hospitals are over-capacity (e.g., contracting for non-hospital alternatives, movement of patients across DHS sites and other safety net hospitals).

Strategy 5: Reduce rates of hospital readmissions at all DHS sites.

Objective 1: Schedule follow-up appointments prior to discharge from DHS hospitals for patients with chronic diseases.

Outcome for success: Appointments scheduled with a specific provider for 95% of patients discharged with heart failure, community acquired pneumonia, or diabetes.

Outcome for success: Decrease in readmission rates for heat failure, community acquired pneumonia, and diabetes.

Strategy 6: Expand use of non-hospital alternatives for people with conditions not requiring inpatient admission (e.g., outpatient surgical center).

Strategy 7: Investigate modifications in scheduling (e.g., elective surgery on weekends) to alleviate hospital crowding.

Strategy 8: Decrease emergency department cycle time.

Outcome for success: Decrease emergency department cycle time by 10% across DHS.

Strategy 9: Develop and implement a standardized inpatient nursing staffing model.

Strategic Goal 3:

Create a modern IT system that improves the care of our patients and assures efficient use of resources.

Strategy 1: Migrate clinical data from the Affinity System set to sunset in 2012 to a system that can meet meaningful use criteria.

Objective 1: Identify systems capable of handling existing data with the capacity to build a fully integrated electronic health record (hospital, ambulatory, pharmacy, etc.) with decision support able to meet the meaningful use criteria.

Objective 2: Procure appropriate system through the county system.

Objective 3: Build a single integrated system for DHS to be hosted on a single remote server.

Strategy 2: Prepare DHS system to share/exchange patient information with community providers.

Strategy 3: Identify and implement important functional components to develop and implement for the electronic health record.

Objective 1: Implement a point of service electronic prescription writer.

Objective 2: Implement a point of service hospital orders system.

Objective 3: Identify other critical new functions for the electronic health record and determine order of taking them live.

Strategy 4: Develop sufficient infrastructure capability for providers to be able to use an electronic health record.

Objective 1: Assess current equipment inventory and needs, including workstations, printers, internet capability, etc.

Objective 2: Assess current IT staffing and needs.

Objective 3: Assess current software and needs.

Strategy 5: Standardize processes prior to computerization.

Objective 1: Determine processes that require standardization.

Strategy 6: Develop a unique patient identifier across DHS with the ability to resolve duplicates in real time.

Strategy 7: Develop a system for assuring that each treating clinician has a unique identifier that connects to the care of a patient.

Strategy 8: Educate staff on need for and skills to enable a successful electronic health record.

Strategic Goal 4:

Assure the long-term financial well being of the safety net health services in Los Angeles County.

Strategy 1: Develop real-time reporting of DHS costs at a cost-center level.

Strategy 2: Develop financial models for accepting bundled, capitated and other non-cost-based payment methods.

Objective 1: Develop a process to financially screen ED patients after the medical screening examination is completed and necessary stabilization is under way.

Strategy 3: Develop necessary infrastructure (e.g., medical staff organization) for handling managed care patients.

Strategy 4: Develop a mechanism to execute contracts between DHS and other health care providers.

Strategy 5: Increase the proportion of patients in DHS covered by Medicaid, Medicare, or private insurance.

Objective 1: Develop a communication/marketing plan to attract and retain publicly and privately insured patients.

Strategy 6: Maximize services within available resources.

Objective 1: Decrease the percentage of denied days.

Outcome for success: Denied days for full scope Medi-Cal is less than 10%.

Objective 2: Develop comparative utilization measures and targets, and communicate findings to providers throughout the system.

Objective 3: Assess utilization data to identify opportunities for decreasing unit costs by increasing the provision of services.

Objective 4: Develop defined benefit packages for populations served by DHS.

Strategy 7: Review DHS procurement processes to identify opportunities to decrease costs without harming quality.

Objective 1: Implement a Supply Formulary to create system-wide material purchasing uniformity.

Strategy 8: Maximize the capacity of DHS facilities, programs, and providers to procure federal, state and foundation funding to enhance systems of care and promote care innovations.

Strategy 9: Fulfill the requirements of the 1115 Waiver and healthcare reform to maximize funding to DHS. (All necessary elements of the 1115 Waiver and healthcare reform implementation are listed in the appropriate sections above.)

Strategic Goal 5:

To foster a culture of empowered staff and community, organized labor, and university partners constantly looking for opportunities to improve the care we deliver.

Strategy 1: Create a culture of ongoing, multi-directional communication across DHS and external partners that reinforce its mission, vision, values, goals and objectives.

Objective 1: Identify all effective means of communication including electronic, printed, mobile and personal modalities.

Objective 2: Deploy all effective methods of communication across DHS and external partners.

Strategy 2: Establish expectations for the development and implementation of quality improvement projects within each DHS unit (e.g., clinic, hospital ward, etc.) where the projects and strategies are chosen by the staff, results are widely disseminated, and best practices are spread throughout the Department.

Objective 1: Determine every functional unit of a size capable of carrying out a quality improvement program and its leader.

Objective 2: Have each leader convene a work group of staff, including front line staff, to choose a project, perform a baseline measure, design a strategy for improvement, and measure post-intervention.

Objective 3: Hold a series of town hall meetings across DHS where front-line staff presents the results of their quality improvement projects.

Strategy 3: Implement standardized outpatient satisfaction surveys across DHS facilities.

Objective 1: Develop a process for communicating results to raise awareness of patients' perceptions of care.

Objective 2: Develop a process for increasing patient satisfaction with care.

Strategy 4: Create a robust labor-management collaboration with meaningful participation by front line staff to achieve DHS mission.

Objective 1: Identify successful staffing and process models from internal and external health care systems and replicate.

Objective 2: Assign staff and seek organized labor designees to tackle three issues chosen by the joint group.

Objective 3: Promote labor-management interaction at the unit level that can help to implement the DHS vision.

Objective 4: Use valid and reliable measurement tools to survey employee experience and communicate findings.

Objective 5: Identify current DHS resources and establish a cohesive training and development infrastructure.

Objective 6: Create a Supervisor/Manager Guidebook with performance expectations, and revise and reissue the Departmental Employee Evaluation and Discipline Guidelines.

Strategy 5: Reinforce the DHS functioning as a *system of care.*

Strategy 6: Deepen DHS relationship with teaching institutions (universities, medical, nursing and pharmacy schools, schools of public health, community college system) to increase the opportunities for training and evaluation research within DHS.

Strategy 7: Create new and support existing paths for professional advancement (e.g., nurse assistants becoming registered nurses, registered nurses become clinical nurse specialists) and professional development (e.g., California Health Care Foundation fellowship program).

Attachment II

Health Services
LOS ANGELES COUNTY

July 13, 2011

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **STATUS REPORT ON THE PROPOSED PLAN TO IMPLEMENT THE 1115 MEDICAID WAIVER INITIATIVE**

Mitchell H. Katz, M.D.
Director

John F. Schunhoff, Ph.D.
Chief Deputy Director

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). The proposed plans should include descriptions of the following: 1) the Low Income Health Programs; 2) payment methodology to private providers that will be included in the Waiver program; 3) protocols for the performance-based Incentive Pool; 4) drawing down Safety Net Care Pool uncompensated care funds; 5) partnership with LA Care to move seniors and persons with disabilities into managed care; 6) preparation of workforce to implement the Waiver; 7) pressing outside technical assistance needs to ensure the County can immediately take advantage of this Waiver; 8) enrollment, revenue, and expenditure projections; 9) monitoring of implementation efforts; 10) implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver; and 11) integration of health, mental health and alcohol and substance abuse programs.

In addition, on December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. Subsequently, we were also asked to include the California Association of Alcohol and Drug Program Executives. As this is related to the Waiver implementation plans, this item will be addressed in the monthly updates provided for the motion outlined above.

The CEO initially reported to your Board November 31, 2010, with updates dated January 31, March 10, April 6, May 5, and June 6, 2011. This status update represents our efforts for the month of May 2011.

As previously reported, on November 2, 2010, the Centers for Medicare and Medicaid Services (CMS) approved the California Section 1115 Medicaid Demonstration, entitled "California's Bridge to Reform," for a five-year period starting November 1, 2010 and many details of this Waiver are still being addressed. Although some details have not been finalized, the Health and Mental Health Services departments are continuing to work on the 12 critical elements/plans of this important initiative, as contained in the Board motions. The attachment contains the most recent information on each of these 12 components.

The most important accomplishments since the previous report were achieving authorization from the State for the Low Income Health Program and implementing the new Healthy Way LA- Matched program, effective July 1, 2011, including mental health services.

The next status report to your Board is targeted for August 1, 2011.

If you have any questions, please contact me.

MHK:JFS:jp

Attachment

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Mental Health
Public Health

WAIVER INITIATIVE

PROPOSED IMPLEMENTATION PLANS

LOS ANGELES COUNTY

Waiver Element/Plan	Status
1. Low Income Health Programs (LIHP): • Proposed scope of health, mental health and alcohol and drug benefits; • Eligibility requirements; • Enrollment, disenrollment and redetermination procedures or limitations; and • Identification and movement of eligible residents into coverage as efficiently as possible.	DHS submitted its LIHP application to the State on February 14, 2011 and received a letter of Initial Approval on April 11, 2011. The next step was an Authorization Process to ensure that program requirements will be met, and a Contract Process on a concurrent track with the Authorization Process. DHS has received notice that is met all program requirements by the July 1, 2011 deadline. DHS implemented its program on July 1, 2011. A contract template was completed by the State and County-specific contracts are expected to be signed by September 30, 2011. DHS is building upon its existing Healthy Way LA (HWLA) program. A total of 61,875 active members have been grandfathered into the new program. Eligibility requirements for enrollees are set forth in the Waiver's Standard Terms and Conditions (STCs). Enrollment and redetermination procedures will comply with State requirements. Consistent with the LIHP application submitted to the State on February 14, 2011, mental health services are available to HWLA members effective July 1, 2011. The mental health delivery system will operate through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA's mental health benefit includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. DHS and DMH have conducted a data match to identify patients using services in both departments; these patients will be given priority for enrollment in HWLA. DMH staff will work with eligible patients needing special assistance to ensure successful enrollment.

Waiver Element/Plan	Status
	DPH decided not to include substance abuse benefits in the LIHP at this time; however, the departments will continue to pursue integrated services outside the scope of the LIHP. See below for additional information on mental health benefits in the LIHP.
2. Proposed payment methodology to private community clinics, hospital partners, and any other providers, including description of how payments will encourage and reward best practices and will ensure that an adequate network of providers exists.	Following the STCs, private community clinics with Federally Qualified Health Center (FQHC) or FQHC look-alike status will be paid according to the Prospective Payment System for services provided to HWLA members. New HWLA agreements with Community Partners, covering HWLA Matched and Unmatched Services were approved by the Board on June 14, 2011 replacing previous PPP contracts, HWLA contracts and SB 474 contracts. Non-network private hospitals will be reimbursed for emergency and post-stabilization care provided to HWLA members. An agreement has been completed and signed with Antelope Valley Hospital. DHS is finalizing negotiations with Santa-Monica-UCLA Medical Center and with a private hospital for patients residing in the east San Gabriel Valley. On February 22, 2010, the Board approved delegated authority to the Director of Health Services to complete and execute these agreements, subject to approval by County Counsel and the Chief Executive Office (CEO). Since payments to FQHCs are based on per visit rate, they do not encourage and reward best practices. DHS will explore the possibility of moving to a bundled or capitated payment. For the LIHP, DHS and Community Partners (CPs) are discussing alternative payment methodologies that may be permitted under the Waiver.

Waiver Element/Plan	Status
3. Protocols for annual Delivery System Reform Incentive Payment Pool (DSRIP), including performance measures around infrastructure development, innovation and redesign, population-focused improvements and urgent improvements to care.	The DSRIP includes numerous milestones within 15 projects that are grouped into four categories. These projects are: Category I: 1) Implement and utilize disease management registry functionality; 2) Enhance urgent medical advice; 3) Enhance coding and documentation for quality data; 4) Enhance performance improvement and reporting capacity; Category II: 5) Expand medical homes; 6) Expand chronic care management model; 7) Integrate physical and behavioral health care; Category III: 8) Measure Patient/Care Giver Experience (Outpatient); 9) Measure Care Coordination; 10) Measure Preventive Health Interventions; 11) Measure Interventions for At-Risk Populations; Category IV: 12) Improve severe sepsis detection and management; 13) Central line-associated bloodstream infection prevention; 14) Reduce complications of surgical procedures; and 15) Venous thromboembolism prevention and treatment. Demonstration Year 7 [the second year of the DSRIP] began July 1, 2011 and will end June 30, 2012.
4. Plans to draw down the Safety Net Care Pool (SNCP) uncompensated care funds, including plan for coverage of individuals between 133 percent and 200 percent of the Federal Poverty Level, to sustain payments to providers until the new Martin Luther King, Jr. (MLK) hospital is fully operational and to claim federal financing for workforce development programs funded by	The programs funded from the South L.A. Fund will continue until the new MLK hospital is fully operational. These include impacted hospital payments, PPP augmentations, strategic initiatives, and funding for operation of the MLK Multi-Service Ambulatory Care Center. Funding for these services will come from the Safety Net Care Pool and the Medicaid Coverage Expansion. The State has used all available existing workforce development programs in the state as the nonfederal share to claim Waiver funds. DHS has worked with the Worker Education and Resource Center [the SEIU 721-affiliated

Waiver Element/Plan	Status
community colleges and universities.	entity] to develop proposals for worker training for FY 2011-12 which support the implementation of the Waiver. The agreement for this was on the Board's June 7 agenda, continued to June 14, 2011.
5. Efforts to partner with LA Care to move seniors and persons with disabilities (SPDs) into managed care.	The State began mandatory enrollment of SPDs into managed care in June 2011, with a 12-month transition period. At the March 1, 2011 Board meeting, DHS obtained delegated authority to complete negotiations and execute agreements, effective March 1, with L.A. Care to implement managed care for SPDs. The County negotiating team (composed of representatives from CEO, DHS and County Counsel) has been meeting weekly with the L.A. Care team. The teams completed work on the two provider agreements, which were executed, effective May 1, 2011. The agreements contain the negotiated "Division of Financial Responsibility (DOFR)", and have the initial four-month contract period rates. Amendments to the agreements will be needed when the next set of rates are announced by the State and when the State, the County and LA Care are able to negotiate a risk-sharing agreement.
6. Preparation of workforce to implement the Waiver, including manpower shortage areas, training needs, and flexibility to better align resources to rapidly changing environment.	Each of the key elements of the DHS strategic plan has been evaluated for its human resource and training needs. The new classification of Certified Medical Assistant was created and an exam is open for applicants. Other efforts currently underway are developing duty statements for care managers, care coordinators, and medical assistants, and identifying temporary staffing needs for HWLA enrollment. Training is completed for staff in the pilot medical home clinics and training is underway for the coaches who will help to spread the medical home model through the remainder of the system.
7. Technical assistance needed to ensure that the County can immediately take advantage of this Waiver, including expertise needed to better integrate mental health and substance abuse related services with federal financing.	Senior leadership from each of the three departments (DHS, DMH and DPH) continues to meet to pursue integration of mental health and substance abuse-related services.

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8. Enrollment, revenue and expenditure projections.	A total of 61,875 existing HWLA members were grandfathered into the new MCE program. Existing DHS and CP patients will initially be targeted for enrollment, with prioritization of homeless, General Relief recipients, and patients using both DHS and DMH services. Negotiations with LA Care were completed regarding the SPD enrollment into managed care. The key objective of the County is having approximately 30,000 patients assigned to DHS facilities as their primary care provider [with specialty and inpatient care], both through patient choice and assignment of those who do not choose. As of July 1, 2011, the net SPD L.A. Care enrollees assigned to DHS for their primary care homes is 8,322, significantly above the target. DHS is offering community partners (PPPs) who receive primary care assignments the opportunity to obtain specialty care from DHS facilities.
9. Regular monitoring of efforts, including any need to establish a Waiver oversight office.	Monitoring of efforts and status reporting are being incorporated into the new Ambulatory Care division, using existing resources. The Deputy Director for Strategic Planning is responsible for oversight of DHS-wide efforts to achieve DSRIP milestones and is working closely with the leadership of each individual initiative to ensure DHS meets and reports on all milestones on time.
10. Implementation timeline for system and infrastructure developments needed to comply with milestones and expectations established by the Waiver.	The DHS Fiscal Outlook, presented on March 29, 2011, included the first projections of costs for Waiver investments and for the Electronic Health Record information system. These projections were also included in the DHS fiscal outlook presented on May 17. DHS staff will continue to refine these numbers, which will be updated in subsequent fiscal outlook memos.
11. Integration of health, mental health and substance abuse programs, including the integration of care and plans for outcome tracking across all three systems.	Mental health services are available to HWLA members effective July 1, 2011. The mental health delivery system is operating through a carved out network of specifically designated mental health programs operated by DMH through directly operated and contracted programs. HWLA members will have a mental health benefit that includes the full range of Medi-Cal reimbursable mental health rehabilitative services based on medical necessity. HWLA members with minimal or moderate mental health needs will

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	preferentially receive mental health services through programs co-located at primary care sites or delivered through collaboration between mental health and primary care providers. Individuals with more specialized and intensive mental health services needs will mostly receive services in more specialized and usually separate mental health outpatient, inpatient, and residential settings in which the full array of mental health rehabilitation programs are available. DMH and DHS have begun implementing the co-located services through an integrated primary care/mental health prevention and early intervention (PEI) program. The program was implemented at El Monte Comprehensive Health Center (CHC) in December, 2010, Roybal CHC in February, 2011, and Long Beach CHC in March 2011. Mental health staff are co-located within each facility and are available to provide PEI services for HWLA members and other patients as capacity permits. This program will be expanded to three additional DHS CHCs and Multi-service Ambulatory Care Centers. DMH also contracted with selected CPs to augment behavioral health training and services at those agencies. In order to expedite distribution of the funds, DMH provided training support to CPs through amendments to existing DHS CP contracts during Fiscal Year 2010-11. DMH also developed contracts with the CPs for ongoing service delivery funding beginning in Fiscal Year 2011-12. HWLA members may also receive services through the patient centered behavioral health home pilot program discussed below.
12. Timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes.	DMH has conducted an initial survey to identify examples of patient-centered behavioral health care homes currently operating successfully in Los Angeles County. Concurrently, the Department initiated the implementation of the MHSA-funded Innovations Plan which will enable the Department to pilot several models for integrated behavioral health homes. Outcome evaluations will be conducted on these approaches which include an integrated mobile health team, an integrated clinic model and models proposed by

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	underrepresented populations. Finally, in collaboration with DHS and DPH, a behavioral health home workgroup was convened. Workgroup members include DMH, DHS and Public Health staff, representatives of several unions, contract providers and social service representatives. During the first two meetings, participants identified core elements of behavioral health homes to be implemented in Los Angeles. The workgroup will meet for a final session to identify actions that can be initiated now in order to prepare Los Angeles County for the potential implementation of behavioral health homes in 2014.